HCFA Physician Incentive Plan
Instructions for PIP Worksheet for Providers

Note: These instructions have been developed as a collaborative effort with representatives of the managed care industry in order to streamline the Worksheet completion process and to standardize interpretations of the HCFA regulations by the Managed Care Organizations (MCOs). Physician groups and IPAs should consult their MCO provider relations representatives, contract managers or associations for more details. Additional information is available on HCFA's web site:
www.hcfa.gov/medicare/physincp/pip-info.htm

A worksheet is completed for each type of sub contract arrangement. **Contracts that are similar should be aggregated for reporting.** Four types of sub contract relationships are believed to be the most common:

a) fee-for-service contracts with no withhold,
b) fee-for-service contracts with withhold,
c) sub-cap contracts without any risk for services provided by other providers, and
d) sub-cap contracts in which the provider is at-risk for services provided by other providers. (The percent amount of referral risk needs to be calculated).

Other contract arrangements not specified above must also be reported.

A HCFA prescribed hierarchy of contracts must be followed and must end at the individual physician level. For example, if a physician group contracts with a group of cardiologists on a capitated basis, the hierarchy would include a) the physician group to cardiology group arrangement and then b) the cardiology group to individual physician arrangement. All disclosures relating to one hierarchy of contracts should be stapled together. The following hierarchies have been identified as possible contract arrangements between physician groups/IPAs with their subcontracted providers.

A Physician group to physician
B Physician group to physician group, *then* physician group to physician.
C Intermediate entity to physician
D Intermediate entity to physician group, *then* physician group to physician
E Intermediate entity to intermediate entity, *then* intermediate entity to physician group, *then* physician group to physician
F Intermediate entity to intermediate entity, *then* intermediate entity to physician group, *then* physician group to physician group, *then* physician group to physician
G Intermediate entity to physician group, *then* physician group to physician

The worksheet is a "snap shot in time" for contracts in effect on January 1 of the reporting year and that are anticipated to continue through the year. **Maximum compensation means maximum possible theoretical compensation based on contract provisions without regard to historical experience.**

General Information: Check the relationship you are reporting from the list provided. Then indicate the parties to the contract in the spaces provided. The physician group or IPA should be listed in the top line. The subcontracted entity or numbers of physicians should be listed on the bottom line.

Example 1: If you are a physician group reporting arrangements with your physicians, check (7) and then give the name of your physician group on the first line and the number of physicians included in the arrangement on the second line.

Example 2: If you are physician group reporting contracts with other physician group(s), check (6) and then give the name of the your physician group on the first line and the name(s) of the contracting physician group(s) on the second line. In this case, be sure to obtain information from the downstream physician group(s) and disclose this data on a PIP Summary Data Form. The entire hierarchy of contracts should be stapled together and submitted to the Managed Care Organization.

Usually, IPAs should report as an intermediate entity if they contract with a mixture of groups and individual physicians. Entities that are organized as physician groups should report as a physician group.

Check the HCFA definitions at the bottom of page 1 of the Worksheet for further clarification. Please note that the first three contractual relationships are not applicable for physician groups and IPAs.

Item #2 – Physician Incentive Plan Information

Item 2 identifies whether the incentive arrangement transfers any risk. A capitation payment or percent of payment is considered a transfer of risk for this item, even if the payment is for services provided only by the contracting physician or physician group.

Check "yes" or "no" as applicable. If "no" is checked, then this disclosure is complete; go to last page and sign form.. If "yes" is checked, identify the type of risk transfer; then go to Item 3.

Risk transfer choices are: "capitation, bonus, withhold, percent of premium or other." More than one choice should be indicated if the arrangement has features of each type of risk-sharing.

Item #3 – Risk for Referrals

Item 3 identifies whether risk is transferred for referrals. *Check "yes" or "no"* as applicable. A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services. If "no" is checked, then this worksheet disclosure is complete. Go to last page and sign form. If "yes" is checked, go to Items 4 and 5 to identify the type and calculate the amount of risk transfer.

Items #4 – Types of Risk Arrangements

Identify the type of risk transfer; then go to Item 5.

Item #5 – Amount of Risk Transferred for Referrals

This Item, in the form of a textbox, addresses the percentage of risk *attributable to referrals to other providers.* Percent of premium is similar to capitation. If the payment based on % of premium covers referral services without any limit on the costs for referral services, then the entire payment or 100% is at risk for referrals. In the workboxes consider % of premium as capitation.

If the percentage is equal to or below 25%, the arrangement is not considered to be at substantial financial risk and this disclosure (3) is complete. If above 25%, proceed to patient pool, Item 6.

Item #6– Physician Group Member Panel Size

Physician groups and IPAs should pool all of their members when they meet HCFA's policy on pooling members, which is shown on the Worksheet.

Stop Loss Information

This section must be completed if the number of members covered is 25,000 or less and the physician or physician group is at-risk for more than 25% of their potential reimbursement. The chart in the Worksheet represents the HCFA required levels of insurance at various panel sizes for individual per patient insurance.

Indicate the name of the stop loss carrier. It is presumed that the carrier would be an insurance carrier or the MCO.

Item #7 – Stop Loss Coverage

Describe the stop loss coverage program. Indicate whether the coverage is per patient or aggregate.

*** * * Date and sign the form as appropriate and keep this form on file in the event of an audit. * * ***

Transfer the information from the Worksheet to the PIP Summary Data Form for Providers and submit to MCO in accordance with directions from the MCO.